YOU #4 AMENDED

PRINTED: 03/23/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		445114	B. WING	the second secon	1	6/2012
	ROVIDER OR SUPPLIER	EINC.	58	EET ADDRESS, CITY, STATE, ZIP COD 37 LYONS VIEW PIKE NOXVILLE, TN 37919	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) . COMPLETION DATE
F 000	INITIAL COMMEN	ent of Deficiencies.	F 000	3/27/12 POC #4 acceptA	ble	
	#29340 was cond Home, on Februa 2012. No deficier complaint #29335 were cited for con	emplaint #29335, #29393, and ucted at Brakebill Nursing ry 23, 2012 through March 6, at practices were cited for or #29393. Deficient practices applaint #29340. Based on emplaint #29340, the facility was be Jeopardy.				
	March 6, 2012. The Administrator Manager were inf	r, Director of Nursing, and Unit ormed of the Immediate ffice of the Administrator on 2:15 p.m.				
	January 16, 2012 Substandard Qua F223, F226 and F of Compliance, w the Jeopardy, wa and corrective ac	eopardy was effective from until March 2, 2012. dity of Care was cited under 309. An acceptable Allegation hich removed the immediacy of s received on March 6, 2012 tions were validated as having y March 2, 2012 during on-site n 6, 2012.		94 · · · · · · · · · · · · · · · · · · ·	•	
	tags continue at a	nce of the Immediate Jeopardy a scope and severity of a "D" Assurance by monitoring of S.				
F 223		3(b)(1)(i) FREE FROM	F 223	TITLE		3/15/12 (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Adminis trator

Ylorma E hinosey

PRINTED: 03/23/2012 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU COMPLE	TED
CTATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			c	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.					_
		445114	B. WING			03/06/2012	
	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODI 37 LYONS VIEW PIKE		
				583	NOXVILLE, TN 37919		
BRAKEBI	LL NURSING HOM	E INC.		I KI	THE COR	RECTION	(X5) COMPLETION
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE APPROPRIATE	DATE
TAG	MEGGE WEST						3113/12
F 223 SS=J	The resident has sexual, physical, punishment, and The facility must or physical abus involuntary sector.  This REQUIRE by: Based on med	interight to be free from verbal, and mental abuse, corporal involuntary seclusion.  Into use verbal, mental, sexual, se, corporal punishment, or usion.  MENT is not met as evidenced ical record review, facility policy of literature on pacemaker	F	: 223	What corrective action will be the resident found to have be deficient practice that facility resident #5 was not protected.  Unable to do immediate corresident had expired on 10/4 diagnosis.  How the facility will identity having the potential to be a practice that resident was a buse?  All current residents with a identified by the DON and charts were reviewed for the series of the series were reviewed for the series with a charts were reviewed for the series of the series with a charts were reviewed for the series of the seri	y failed to ensed from abuse rective action 27/11 Terminal other resides of the feeted by the not protected a pacemaker of the feeted by the feeten feeted by the feeten feeted by the feeten feeted by the feeten f	ed for by the sure that ? as d deficient from
	interview, the facility's faserious harm, resident #5 as Nurse (LPN) fresident #5 will pacemaker will placing of the from function for resident #5	trator, Director of Nursing, and Un	of ker ath		frequency of required che 2/29/12. A policy and proc checks was developed on Nurse, Medical Director at Telerhythmics represent policy/procedure). Staff w policy and procedure on What measures will be pound the deficient practice doc All pacemaker check bot secured in the unit medicand the two unit manage possession of the key to	edure for pace 2/29/12 by the input from a tive (attached a 3/13/12.  The input from a tive (attached a 3/13/12.  The input from a tive for this room at a the check a	emaker e Quality the l on this ensure that ked and The DON ain all times. es are
	Jeopardy in the office of the Administration March 5, 2012, at 2:15 p.m.  The findings included:				Patients scheduled pac- performed on day shift only. The Nurse perform Unit Managers to obtain and sign out on pacem	ming will notif n pacemakers aker log.	y the DON or check device
1	Resident #5	was admitted to the facility on	1			15 continuation	on sheet Page 2 c

	AND ANDRANGEDVICES			*	PRINTED: 0 FORM A OMB NO. 0	PPROVED
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	& MEDICAID SERVICES			TO VOTION	(X3) DATE SUF	RVEY
STATEMENT OF DEFICIENCIES	1211 DROVIDERISULT ELIVERY			CONSTRUCTION	COMPLET	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI			03/06	S
	445114	B. WIN		THE CODE	03/00	120
NAME OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE 7 LYONS VIEW PIKE		- 1
BRAKEBILL NURSING HOME	INC.		KN	OXVII I E. TN 37919	CTION	(X5) COMPLETION
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAI	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
F 223 Continued From p January 17, 2011 Cardiac Dysrhythe Atrial Fibrillation, Hypertension, Hy Obstructive Pulm Chronic Pain.  Medical record re dated October 14 was rarely able to sometimes able short and long to severely impaire two person assist transfers; was n person assistan and was inconti  Medical record cardiac pacema May 26, 2011 a "Pacemaker: (specific type of February 5, 20 Syndrome - a r pacemaker car  Medical record Physician Ord		a	223	The validation of a physician of checks will be done before check documented on the log by the managers to return and secure box. This process was implemed All dayshift licensed nurses at will be trained regarding pacer by the DON and DON will verify competency as pacemakers of orders for frequency of pacen usually ordered on a 3-6 month physicians from 3/12/12 to the been no scheduled pacemaker has a master list of all resides pacemaker checks with schemangers will be trained on pacemaker check date. The location of the revised pacemaker policy policy and procedure for pacemaker check skill and ethe revised pacemaker policy and procedure for pacemaker the Unity policy and procedure for pacemaker the will staff training received the Unity policy and procedure for pacemaker will staff training received the Unity policy and procedure for pacemaker will staff training received the Unity policy and procedure for pacemaker will maintain a material staff and update a hires. A licensed nurse where the master list will not be a staff and update a staff and update a hires. A licensed nurse where the master list will not be a staff and update a	DON and/or of pacemaker pented on 3/1: and unit coord maker check fy all staff for theck are donakers check the basis by the state of the checks. The state of the check are checks accemaker check are checker check of the maker check of the maker check of the check	unit check 3/12. dinators skills de. As as are the have de DON dire Unit decks by didated arding lical rector of maker 3/13/12. by the ced by and Unit ll trained th any new tified on mform this

FORM CMS-2567(02-99) Previous Versions Obsolete

DNR status.

"DNR" (Do Not Resuscitate) on January 17, 2011

and the order was to be continued.

Medical record review of the Medication

Administration Record, dated October 1 - 31,

2011, revealed the resident was identified as

Event ID: 1Y8P11

Facility ID: TN4702

If continuation sheet Page 3 of 29

3/13/12

skill. Training for these individuals will be scheduled with date of resident's next scheduled

and licensed staff member.

pacemaker check. Pacemaker check log will also

include verification of the physician order by DON

		40				PRINTED: FORM A	PPROVED
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES				OMB NO.	0938-0391
CENTERS	FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE	E CONSTRUCTION	COMPLET	TED
STATEMENT O	F DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUIL			234.0	3 \
AND PLAN OF	<b>50</b> 1.1.1—53.1.5	in a constant of the constant	B. WIN	G		03/0	6/2012
		445114	1	CTDE	ET ADDRESS, CITY, STATE, ZIP CODE		2
NAME OF PR	OVIDER OR SUPPLIER			583	37 LYONS VIEW PINE		
BRAKEBI	LL NURSING HOME	INC.		KN	PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES 'Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE APDEFICIENCY)	PROPRIATE	DATE
F 223	Continued From produced of the Assistant (Certified Natural of the	page 3 Priview of the Physician's Order, 3, 2011, no time noted, revealed over of Attorney) sign Advance - Physician's Order for Scope of MO (Comfort Measures Only)"  eview of the Physician's Order, 9, 2011, no time noted, revealed ent) CMO DNRno labs, no intravenous fluids), no antibiotics, ding)"  review of the Clinical Record revealed the following sequential 22, 2011, at 2:30 a.m "resting Cotober 23, 2011, at 4:00 a.m iods of apnea (not breathing for comfortable"; October 23, 2011, at 4:00 a.m iods of apnea noted"; October 23, 2016; on p.m. (shift) - "resting a.m "restingperiods of apnea hoted"; October 24, a.m "restingperiods of apnea hoted"; October 27, 2011, at 1:40 p.m with) no respirations or pulse. Ideath"; October 27, 2011, 7:00 a.m. shift) - "Deactived (questionable emaker" signed by Licensed se (LPN) #1; October 27, 2011, at (named) funeral home here to day to funeral home."  cility Incident Report for Resident my 16, 2012, no time noted, signed to Administrator, revealed "CNA arsing Assistant) #1 entered nursing Assistant) #1 entered nursing everal complaints about LPN #1. why a magnet was placed on the day (resident #5)	g 1. #5, d by	223	After pacemaker check compl	eted the care of pacemake mented in the l be monitore does not re r checks will weekly basis I Nurse wee a will be imm is process wance is 100% a checked mon r Times Four irector, Admi tor, MDS Coo rector, Dietar mance Super	ed to cur:  be (every kly for 6 nediately vas at the end athly and . The Ql inistrator, ordinator, y Manager, visors and
	Questioning	why a magnet was placed on the day (resident #5) CNA #1 did not work on the day	of		Facility ID: TN4702	If continuat	ion sheet Page 4 of 29

CENTERS FOR	RMEDICARE	& MEDICAID SERVICES	Lova M	II TIPI I	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEMENT OF DEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	386 88	LDING			c	
AND FEAR OF CORE			B. WIN			19.0	6/2012	
NAME OF PROVIDE		445114	B. VVII	STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
BRAKEBILL NU	JRSING HOME	INC.		KN	OXVILLE, TN 37919 PROVIDER'S PLAN OF CORP	RECTION	(X5) COMPLETION	
(X4) ID PREFIX TAG	CACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	-IX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		DATE	
F 223 Cont (resi #1) of Adm Nurs Rev date the (Ter faci Rec and hor lot contain the Contain of t	tinued From p dent #5's) dea discussed all o hinistrator and sing)" liew of facility ed February 1: Director of Nu nnessee Bure lityinvestigat quested (resid di access to an horedAdmini- erview by phon 12, at 8:25 p.r 11, around lur sident #5 alon served "a dou vered" device ontinued interview reveal e device was continued interview reveal dispersion sor lid by CNA #1 as not to be us link #1 reporte anuary 16, 20	age 4 ath October 27, 2011(CNA complaints with (named) (named) DON (Director of  Incident Report for Resident #5, 3, 2012, at 1:00 p.m., signed by Irsing, revealed "(named) TBI au of Investigation) at ting the death of (resident #5). Itent #5's) entire medical record y staff requested. Request istrator present"  Ine with CNA #2 on February 29, inc., confirmed on October 27, inchtime, CNA #2 was cleaning g with CNA #3 and #4 and ghnut shaped red plastic on the chest of resident #5. Fiew confirmed the resident was ing at the time. Continued ed CNA #2 asked LPN #1 what and was told to "leave it alone". Fiew confirmed the CNA had device before. Continued the CNA was talking about the continued that the device was a magnet are sed on a dying pacemaker paties and the incident to Administration of the continued the incident to Administration of the continued that the device was a magnet are sed on a dying pacemaker paties and the incident to Administration of the continued the incident to Administration of the continued that the device was a magnet are sed on a dying pacemaker paties and the incident to Administration of the continued the continued the incident to Administration of the continued th	e as and ant.	223				
2  h	012, at 10:10 elping clean r	a.m., confirmed CNA #3 was esident #5 on October 27, 2011 what looked like "a roll of red and the left side of the chest" of resident	i ent		Facility ID: TN4702	If continuation	sheet Page 5 of 2	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	COMPLE	
		445114	B. WING	5	03/0	6/2012
	ROVIDER OR SUPPLIER	E INC.	s	STREET ADDRESS, CITY, STATE, 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 223	#5. Continued into was breathing at a confirmed when L device the LPN to Leave it alone". CNA #3 stated so CNA #1 overhear incident and told used with a pace.  Interview by phor 2012, at 10:40 a. helping clean resured and 10:00 a.n. like a rolled up wo chest" of residen revealed the resigned the resigned with the skin of the collarbone are linterview by phor Administrator on review of an und received by the finite signed by the As 16, 2012, regard presence for the February 13, 20: Administrator was nature of the incident pacemaker when the signed LPN #1 magnet on reside pacemaker when the signed when the signed LPN #1 magnet on reside pacemaker when the signed when the signed LPN #1 magnet on reside pacemaker when the signed when the signed LPN #1 magnet on reside pacemaker when the signed when the signed LPN #1 magnet on reside pacemaker when the signed when the si	the time. Continued interview LPN #1 was asked about the old CNA #3 "It's a magnet. Continued interview confirmed ometime around Christmas 2011 of CNA #3 talking about the CNA #3 a magnet was not to be maker.  The with CNA #4 on March 3, m., confirmed CNA #4 was ident #5 on October 27, 2011, n., and observed what "looked that tape on the left side of the tape. The continued interview dent was breathing. Continued ed the device was in contact ne resident and visible between	F 22	23		

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	COMPLETED C	
		445114	B. WING _		03/06/20	012
	ROVIDER OR SUPPLIER	INC.	5	REET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE 1 CC	(X5) OMPLETION DATE
F 223	September 25, 20 not be subjected to means willful inflict Review of literature by Medscape, dat "Magnet Inhibition magnet over a pe "reprograms" the cease to cause to mode. It does not pacemaker type in for beginning-of-licindicator (ERI), as if the device compaphication of a magnet of the pacemaker/ICD (magnets are avaishould be aware pacemaker/ICD in device"  Interview in the Amedical Director, attending physicial 11:30 a.m., reveal knowledge of the magnet on the city, 2011 until Fecompleted a photopirector. Contin Physician's order on resident #5 for the magnet of the process of the proces	02, revealed "Residents must o abuse by anyoneAbuse	F 223			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445114			ULTIPL LDING NG	E CONSTRUCTION	C 03/06/2012		
NAME OF D	ROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	00/0		
	ILL NURSING HOW		5837 LYONS VIEW PIKE KNOXVILLE, TN 37919					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAC	2008834	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 223	company perform specified dates b interview confirm	ning the readings on the y the company. Continued ed there was no reason for a he room or on the chest of any	F	223		3		
	Administrator's of confirmed LPN # of resident #5 what alive at the time	ch 5, 2012, at 3:30 p.m., in the office with the Administrator to placed a magnet on the chest no had a pacemaker and was the magnet was placed on the on October 27, 2011.				i.		
	January 16, 201 written Acceptat which removed was received on actions were val on March 2, 201 documents and on March 6, 201	Jeopardy was effective from 2 through March 2, 2012. A ble Allegation of Compliance, the immediacy of the jeopardy, March 6, 2012 and corrective idated as having been completed 2 through review of the facility staff interviews conducted on-site 2. The verification of the mpliance was confirmed by:						
	1.) Reviewing the Abuse Prevention include more conto identification.	ne facility's revised policy for on/Reporting Investigation to omprehensive information related preventing occurrences, tigating, protecting, and						
	Reviewing the inservice record procedure.	ne facility's new policy and ds for Pacemaker Checks				<b>*</b> 66		
	inservice recor	he facility's new policy and ds for the new fibrillator procedure.						

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Event ID: 1Y8P11

Facility ID: TN4702

If continuation sheet Page 8 of 29

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED		
		445114	B. WING _		03/06/	2012	
	ROVIDER OR SUPPLIER	E INC.	5	REET ADDRESS, CITY, STATE, ZIP CODE 837 LYONS VIEW PIKE (NOXVILLE, TN 37919			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 223	4.) Conducted into on all units, Hous Activity staff to en on Abuse Preven were able to iden and how to report inservice records 2012, to ensure a returning to work staff to be inservite work if staff had inservices.  5.) Reviewed an residents with particular and the staff to be inserviced.	erviews with CNA's and LPN's ekeeping staff on all units, and isure all had received inservices tion/Reporting investigation and tify types of abuse and when it. Reviewing of the facility's on abuse, dated March 1 -2, all staff were inserviced prior to it. Review of the facility plan for it.	F 223				
F 22 SS=	residents on Cor  7.) Reviewed an of incidents of su March 2, 2012 to the procedures of the procedures of the procedures of the procedures of the procedure of	additional three medical records aspected abuse reported since of ensure the facility was following for reporting and investigating.  The continues at a "D" level for active actions. The facility is not a plan of correction.	F 22	26		3/15/12	
	The facility mus	cedures that prohibit	-				

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		AND HUMAN SERVICES				FORM AF OMB NO. 0	938-0391
DEPARTM	ENT OF HEALTH	& MEDICAID SERVICES		-	- CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
CENTERS O	F DEFICIENCIES	I A 11 DK MIDELMOOL I FIELMOE"			LE CONSTRUCTION		1
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		03/06	
		445114	B. WI				12012
		443114		STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF PR	OVIDER OR SUPPLIER			ES	237 LYONS VIEW PINE		
BRAKEBI	LL NURSING HOME	INC.		K	NOXVILLE, TN 37919 PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
D. G. I. I.		TENENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION	SHOULD BE	DATE
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE TA		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	
TAG	REGULATORY OR	ESC IDEITI TITLE					1-112
<del></del>							3112/12
F 226	Continued From	page 9	1	226	s SS=J		
1 220					ill be acco	mplished for	
	This REQUIREM	ENT is not met as evidenced	,	What	corrective action will be according to corrective action will be accorded by esident found to be affected by	the deficient	
	10.4.000			the r	esident found to be allected by tice that facility failed to report	, investigate	
	Based on medic	al record review, review of maker devices, facility policy		prac	tice that facility failed to report report in a timely manner of all	eged abuse or	1
				and	report in a timely manner of all ort the alleged perpetrator or ab	ouse and failed	
	1 - Landian the tol	Allow Tailed to Chisars willed		repo	otify state?		
	completion of at	allegation of abuse		10 11	Dury State :	/roporting	
68 6				Poli	icy on resident abuse prevention	12 and 3/1/12 b	y
	alleged perpetra	ator of abuse; and failed to notify		inve	icy on resident abuse prevent estigating was revised on 2/29/ estigating was revised and Unit M	lanagers. Any	
23				the	Director of Nursing and	ates were	1
	abuse for one r	esident (#5) of sixteen residents		ass	ociate not present on above of price of above of price of the process of the proc	rior to beginning	g
	reviewed.			pro	ovided one on one education pro- heduled work. A master list is r	naintained by	
	The facility's fa	ilure caused or was likely to caus	е		and all accordates		
				tra	DON to insure all associates in ining. This process is on-going	g due to	,
	resident #5 as	a result of the facility failure to	1	en	ining. This process is on-going nployee leaves etc. Associates	are expected to	
	hima als	and commerce mycogasis.		in	form their supervisor/administration	ithout fear of	
		ouse; failed to immediately lleged perpetrator of abuse; and		cc	oncern they have at any time to	need to validate	e
	suspend the a	the State in a timely manner of a	n	re	prisal. Education included and hysician order for any patient i	ntervention.	1
1	allegation of a	buse for resident (#5).		P	hysician order for any pure	20 m	
1	allegation of a	and lin	+		low the facility will identify oth	er residents	
	The Administr	rator, Director of Nursing, and Un		h	aving the potential to be and	ed by the same	
	Manager were	e informed of the Immediate			leficient practice r		1
	loopardy in it	Je office of the Marining	1			to be affected	by
	March 5, 201	2, at 2:15 p.m.		-	All residents have the potential the deficient practice. Revised	policy of report	ing,
	The findings	included:		1	the deficient practice. Noting a	huse was	
					preventing and investigating at developed on 2/29/12 by the Address in Section 1985	dministrator and	12
	Resident #5	was admitted to the facility on			developed on 2/29/12 by the Att	rviced on 2/29/	ned
	January 17,	2011 With diagnoses the Implant	t,		DON. All associates were in-sea and 3/1/12 on all forms of abus	se and encourag	av
1	Cardiac Dys	rnythmia with a document Thera	ару,		and 3/1/12 on all forms of abusto report any unusual events to	nat ne or sile in	risal.
1	Atrial Fibrilla	mon, Chronic Anemia, Chron	nic		feel uncertainty regarding in	nmediate	1
	Hypertensio	n, Hyperlipidentia, Altomorphisms, Pulmonary Disease, Depression,	and		The revised policy required ah	user and timely	,
	Obstructive Chronic Pai	n			The revised policy requires in suspension on the alleged ab notification to the state of val	idated incident.	
	Chronic Par	11.			notification to the state of var	<b>7</b>	sheet Page 1

ALTH	AND HUMAN SERVICES				FORM AND. 0	938-0391
CARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETE	ED
	445114	B. WI		TIR CODE	The state of the s	2012
	INC.		58	37 LYONS VIEW PIKE		
ARY ST	ATEMENT OF DEFICIENCIES	PRE	FIX	PROVIDER'S PLAN OF CORRECTION SHO		(X5) COMPLETION DATE
From poord revoer 14 able to able to able to assist was no istance continuous for 2011 and aker. Mype of 5, 2011 and aker. Mype of 5, 2011 and aker. Mype of the result of	page 10 view of the Minimum Data Set, , 2011, revealed the resident ounderstand others; was o make self understood; had rm memory deficits; had decision making skills; required tance for bed mobility and on-ambulatory; required two se for all activities of daily living; ent of bowel and bladder.  eview of the results from the ker monitoring company, dated and August 25, 2011, revealed Medtronic, Inc. VERSA VEDR01 device implanted)Implant date 0Diagnosis: SSS (Sick Sinus laffunction of the heart's primary sing an abnormal heart rhythm) review of the recapitulation rs, dated October 1 - 31, 2011, sident was initially ordered to be Resuscitate) on January 17, 201 vas to be continued.  review of the Medication Record, dated October 1 - 31, the resident was identified as	F iii waa a a a a a a a a a a a a a a a a	The Dommed veeke been vailable with that the Abus mand be do assu on-guincid Unit State 24 h Wee occurrence oc	ON reviews all incidents/alleged intely when notified and is availands/holidays by phone. In times to the Unit Manager will be designed.  The deficient practice does not receive in-services will be done quarter ated education by the DON/or designed monthly by DON and Unit Mare staff understanding effective 3 and incident investigation tool of the effective 3/12/12. This is to be designed at a property of the cours of incident occurrence (attacked staff is to notify administrative that may need to be stated to be reported to the DON immediation by Policy. Sample size is	abuse able on of her mated to be o ensure cur? rly as esignee. g abuse will nagers to 8/2/12 and on all alleged e DON and porting to lone within ched form), torregarding e reported. o validate n. Variances diately for	
	CARES  PPLIER HOME FOR PORT OF THE PORT OF	HOME INC.  ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)  From page 10  ord review of the Minimum Data Set, Deer 14, 2011, revealed the resident able to understand others; was able to make self understood; had appaired decision making skills; required assistance for bed mobility and was non-ambulatory; required two decisions and bladder.  Cord review of the results from the exemaker monitoring company, dated 2011 and August 25, 2011, revealed aker. Medtronic, Inc. VERSA VEDR01 and August 25, 2011, revealed aker. Medtronic, Inc. VERSA VEDR01 are a malfunction of the heart's primary are causing an abnormal heart rhythm).  Becord review of the recapitulation of Orders, dated October 1 - 31, 2011, the resident was initially ordered to be a continued.  The cord review of the Medication ration Record, dated October 1 - 31, 2011, we aled the resident was identified as trus.  The record review of the Physician's Order, cotober 18, 2011, no time noted, revealed POA (Power of Attorney) sign Advance and POA (Power of Attorney) sign Advance and POA (Power of Attorney) sign Advance and POA (Power of Attorney) sign Advance POA (Power of	CARE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:  445114  B. WIT  445114  B. WIT  445114  B. WIT  A. BUI  A. BUI  A. BUI  A. BUI  B. WIT  B	CARE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445114  A BUILDING  B. WING  ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)  From page 10  ord review of the Minimum Data Set, Der 14, 2011, revealed the resident able to understand others; was able to make self understood; had ong term memory deficits; had apaired decision making skills; required was non-ambulatory; required two distance for all activities of daily living; continent of bowel and bladder.  Cord review of the results from the incemaker monitoring company, dated 2011 and August 25, 2011, revealed aker: Meditronic, Inc. VERSA VEDR01 (Appe of device implanted)Implant date: Both 2011, including an abnormal heart rhythm) The resident was initially ordered to be a look of the resident was initially ordered to be a look of the resident was initially ordered to be a look of the Results from the record review of the Medication profession of the heart's primary are causing an abnormal heart rhythm) The resident was initially ordered to be a look of the record review of the Medication ration Record, dated October 1 – 31, 2011, the resident was initially ordered to be a look of the record review of the Medication ration Record, dated October 1 – 31, 2011, the resident was initially ordered to be a look of the record review of the Medication ration Record, dated October 1 – 31, 2011, the resident was initially ordered to be a look of the record review of the Medication ration Record, dated October 1 – 31, 2011, the resident was initially ordered to be a look of the record review of the Physician's Order, cober 18, 2011, no time noted, revealed POA (Power of Attorney) sign Advance  The Distribution of Attorney of Attorney of Score of Score of Attorney of Score of Score of Attorney of Score of Sc	CARE & MEDICAID SERVICES  (X1) PROVIDERISPIPEIRICUA IDENTIFICATION NUMBER:  445114  PPLIER  445114  STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919  PROVIDERS PLAN OF CORRES (EACH CORRECTIVE ACTION SHE FICEINCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRES (EACH CORRECTIVE ACTION SHE FICEINCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORREST (EACH CORRECTIVE ACTION SHE CROSS-REFERENCE TO THE APPLICATION SHE CROSS-REFERENCE TO SHE CROSS-REFERENCE TO THE APPLICATION SHE CROSS-REFERENCE TO	ALTH AND HUMAN SERVICES  CARE & MEDICAID SERVICES  S (X1) PROVIDER/SUPPLETRICIA DENTIFICATION NUMBER:  445114  A 45114  STREET ADDRESS, CITY, STATE, ZIP CODE 537 LYONS VIEW PIKE KNOXVILLE, TN 37919  PROVIDERS PROVIDERS PYFULL PRY OR LSC IDENTIFYING INFORMATION)  From page 10  ord review of the Minimum Data Set, Der 14, 2011, revealed the resident able to understand others; was able to make self understood; had ong term memory deficits, had paginered decision making skills; required assistance for bed mobility and was non-ambulatory; required two sistance for all activities of daily living; continent of bowel and bladder.  cord review of the results from the cemaker monitoring company, dated D11 and August 25, 2011, revealed aker. Meditonic, Inc. VERSA VEDR01 page of device implanted)Implant date: 5, 2010Dignosis: SSS (Sick Sinus er a maffunction of the heart's primary er causing an abnormal heart rhythm)."  secord review of the recapitulation Orders, dated October 1 - 31, 2011, the resident was initially ordered to be a long to receive the Medication ration Record, dated October 1 - 31, 2011, the resident was identified as tus.  The DON reviews all incidents/alleged abuse immediately when notified and is available on weekends/holidays by phone. In times of her absence the Unit Manager will be designated to be available.  What measures will be put into place to ensure that the deficient practice does not recur?  Abuse in-services will be done quarterly as mandated education by the DON/or designee.  Random staff interviews (25) regarding abuse will be done monthly by DON and Unit Managers to assure staff understanding effective 3/2/12 and on-going. Incident investigation tool on all alleged incident abuse will be complete by the DON and incident abuse will be complete by the DON and incident abuse will be complete by the DON and incident abuse will be complete by the DON and incident abuse will be complete by the DON and incident abuse will be complete by the DON and incident abuse will be completed. Chart

Medical record review of the Physician's Order,

)FPARTM	ENT OF HEALTH	AND HUMAN SERVICES				PRINTED: 0 FORM AI OMB NO. 0 (X3) DATE SUR	938-0391
CENTERS	FOR MEDICARE	& MEDICAID SERVICES	(X2) ML	ILTIPLE	E CONSTRUCTION	COMPLET	ED
TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		Special Control	\ c	
ND PLAN OF	CORRECTION	IDENTII IOATTIST TEMPER				03/06	
		445114	B. WIN			03/00	180
		443114		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER			683	T LYONS VIEW PINE		er .
	LL NURSING HOME	EINC.		KN	OXVILLE, TN 37919	OTION	(X5)
BRAKEBI			ID	1	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	X	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		
170							3/12/12
			F	226			3.
F 226	Continued From	page 11	1		III he mori	tored to	
	dated October 19	2, 2011, no time noted, revealed	H	low th	ne corrective action will be mon	not recur?	1
			е	nsur	ne corrective action will be interested that the deficient practice does	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1
	x-rays, no IV's (ir	ntravenous fluids), no antibiotics,	١.	! .!	ent reports will be reviewed daily	by the	
	no TF (tube feed				A wain stors allu/ul Duin.		
	se died roomd r	eview of the Clinical Record	- 1		II III action allu da il	CCMC	
			C 10				
1	1	TOMENTALISM OCCUPIED TO THE PROPERTY OF THE PR					
	quietlyperiods	s of apnea noted"; October 24,	a				
1	noted"; Octob	per 27, 2011, at 1.40 pm.					
		with) no respirations or pulse. eath"; October 27, 2011, 7:00 a.m.			I ALL Shoroafter Di-dilliudill "		
		Liet I IDAL IIVEU (GGCCIIC.			Han consists of Medical Dive	,	
	to 3:00 p.m. (s	maker" signed by Licensed			nintee consider ninistrator, Pharmacist, DON, Ur rdinator, MDS Coordinator, Reh		
							g,
	10.00 = 100 "/1	named) luliciai lioilio		Acti	vity Director, Dietary Manager, i ntenance Supervisors and Medi	cal Records.	
	transport body	to funeral home."		Mai	ntenance Supervisors		_
	il direction of	and for Posident #	5.				
1	Review of fac	ility Incident Report for Resident #	by		,		
1	dated Januar	7 16, 2012, 110 tillion led " CNA					
	the Assistant	Administrator, revealed "CNA	g				
	(Certified Nur	Administrator, revealed with the sing Assistant) #1 entered nursing about LPN #1.	-				1
	office had se	veral complaints as placed on	į				1
	Questioning '	why a magnet was president #5)			0	3	
1	Resident #5	s chest of the day on the day o	f				
	diednoted	cnA #1 did not work on the s) death October 27, 2011(CNA					
	(resident #5	ed all complaints with (named)					
	#1) discusse	or and (named) DON (Director of			į		
1	Administrato	and themselves					
1	Nursing)"		+#5		15		
	Daview of fa	acility Incident Report for Resident	t #5,				
	dated Fehri	acility Incident Report of Resources pary 13, 2012, at 1:00 p.m., signed	ı Dy			it it in the	sheet Page 12
	ualed i obie		1V0D11		Facility ID: TN4702	If continuation	Shoot i aga
1		Sheelete Event ID:	TYOPTI		30 20 T \$ 3 OF 12 POLICE POPPER S 1 1 1 1		

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING	E CONSTRUCTION	C 03/06/2012	
	ROVIDER OR SUPPLIER		•	583	ET ADDRESS, CITY, STATE, ZIP COI 17 LYONS VIEW PIKE IOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 226	the Director of Nu (Tennessee Bure facilityinvestiga Requested (resid and access to an honoredAdmini Interview by phor 2012, at 8:25 p.m 2011, around lum resident #5 along observed "a dour covered" device Continued interview reveals the device was a Continued interview reveals the device was a Continued interview reveals observation som told by CNA #1 was not to be us CNA #1 reported January 16, 2010. Interview by phor 2012, at 10:10 a helping clean reand observed white tape on the factor of the LPN Leave it alone."  CNA #3 stated.	arsing, revealed " (named) TBI au of Investigation) at ting the death of (resident #5). ent #5's) entire medical record y staff requested. Request strator present"  The with CNA #2 on February 29, n., confirmed on October 27, chtime, CNA #2 was cleaning a with CNA #3 and #4 and ghnut shaped red plastic on the chest of resident #5. iew confirmed the resident was ng at the time. Continued and was told to "leave it alone". iew confirmed the CNA had device before. Continued and the CNA was talking about the netime around Christmas and was that the device was a magnet and ad the incident to Administration on		226			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING  B. WING	E CONSTRUCTION	C 03/06/2012	
	ROVIDER OR SUPPLIER		583	ET ADDRESS, CITY, STATE, ZIP COD 7 LYONS VIEW PIKE OXVILLE, TN 37919	0	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL PROPERTY OF THE PROVIDER OF	SHOULD BE	COMPLETION DATE
F 226	incident and told used with a pace  Interview by phor 2012, at 10:40 a. helping clean resaround 10:00 a.n like a rolled up we chest" of resident revealed the resident revealed the resident review confirm with the skin of the collarbone at Interview by phone Administrator on review of an undereceived by the signed by the As 16, 2012, regard presence for the February 13, 20 Administrator with the skin of the february 13, 20 Administrator with the skin of the february 13, 20 Administrator with the skin of the february 13, 20 Administrator with the skin of the february 13, 20 Administrator with the skin of the february 13, 20 Administrator with the skin of the february revealed LPN # magnet on reside pacemaker when the skin of the february revealed LPN # magnet on reside pacemaker when the skin of the february revealed LPN # magnet on reside pacemaker when the skin of the february revealed LPN # magnet on reside pacemaker when the skin of the february revealed LPN # magnet on reside pacemaker when the skin of the s	CNA #3 a magnet was not to be maker.  The with CNA #4 on March 3, m., confirmed CNA #4 was ident #5 on October 27, 2011, n., and observed what "looked hite tape on the left side of the trest tree was in contact the resident and visible between and breast area.  The with the Assistant March 2, 2012, at 3:30 p.m., and stacility on March 7, 2012 and stacility on March 7, 2012 and stated written statement, dated as acility on March 7, 2012 and stated written statement, dated as acility on March 7, 2012 and stated written statement, dated as acility on March 7, 2012 and 12, confirmed the Assistant Administrator events of January 16, 2012 and 12, confirmed of the exact ident reported on January 13, resent while TBI interviewed LPN 13, 2012. Continued interview 1 informed to TBI about placing a lent #5's chest to deactivate the en resident #5 was still living.  The collity policy Abuse Policy, dated 2002, revealed "Residents ojected to abuse by means willful infliction of to develop and implement	F 226			

STATEMENT AND PLAN OI	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	LE CONSTRUCTION	1	C
		445114	B. WI	IG		03/06	6/2012
	ROVIDER OR SUPPLIER			58	EET ADDRESS, CITY, STATE, ZIP CODE 37 LYONS VIEW PIKE NOXVILLE, TN 37919		
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F 226	complainantimmedia phone to the Staltwenty-four hours within forty-eight Review of the factory and incidentsimmedia an incident retoreview all incidentsimmedia and i	mediately respondreport by e of Tennessee within s, followed by a written report hours"  cility policy Incident/Accident and investigating, dated June 29,		226			

PRINTED: 03/23/2012 FORM APPROVED OMB NO. 0938-0391

STA	TEMENT (	S FOR MEDICARE  OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 03/06/2012	
1		ROVIDER OR SUPPLIER	445114 EINC.	583	ET ADDRESS, CITY, STATE, ZIP CODE 17 LYONS VIEW PIKE OXVILLE, TN 37919		
$\vdash$	(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
	F 226	pacer's battery neinterrogation or more performed by techniqueAlthough techniqueAlthough techniqueAlthough techniqueAlthough techniqueAlthough techniqueAlthough techniqueThe magnets are available and the magnet of the magnet on the completed a phough technique to the completed a phough technique to the company performagnet on the company performagnet to be in resident with a specified dates interview confirmagnet to be in resident with a Review of the Record for LPI March 2012, rethrough Februtor a total of 20 the Activity Thus to a total of 20 the Activity Thus immediately a simulately a simulately a simulately and the footbody technique in the footbody technique	seds to be replaced. Further transpulating of the device should an individual skilled in the truth many different branded internal cardiac defibrillator) is that in general any magnet can be used to inhibit the Activity Therapy room with the who was the resident's ian, on February 29, 2012, at called the Medical Director had not allegation of LPN #1 placing a chest of resident #5 on October ebruary 13, 2012 when the TBI one interview with the Medical nued interview confirmed not any reason other than initoring as directed by the reming the readings on the by the company. Continued med there was no reason for an the room or on the chest of any	16			
	1			(OD11	Facility ID: TN4702	If continuation s	sheet Page 16 o

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1Y8P11

Facility ID: TN4702

NAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME INC.    SUMMARY STATEMENT OF DEFICIENCIES   STREET ADDRESS, CITY, STATE, 2 IP CODE   STATE, 2 IP CODE	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		PLE CONSTRUCTION  G	COMPLETED	
NAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME INC.    Continued From page 16   Interview confirmed LPN #1 was not suspended until February 16, 2012. Review of the facility Time and Attendance Records for February 2012 revealed the LPN worked on February 24 to work in the facility on non-resident care duties; LPN #1 was not terminated until February 28, 2012; and the facility and not completed its investigation until March 1, 2012.  Interview on March 5, 2012, at 3:30 p.m., in the Administrator's office with the Administrator's of			445114				03/0	
PREFIX TAG  FREDIA DEPOLEPTION SHOULD FRED THE APPROPRIATE DEPOLEPTION THE APP					58	837 LYONS VIEW PIKE (NOXVILLE, TN 37919		i an
interview confirmed LPN #1 was not suspended until February 16, 2012. Review of the facility Time and Attendance Records for February 2012 revealed the LPN worked on February 24, 27, and 28, 2012 (for a total of 3 days). Continued interview confirmed LPN #1 was allowed to return to the facility on February 24 to work in the facility on non-resident care duties; LPN #1 was not terminated until February 28, 2012; and the facility had not completed it's investigation until March 1, 2012.  Interview on March 5, 2012, at 3:30 p.m., in the Administrator's office with the Administrator confirmed the facility failed to immediately suspend the accused perpetrator, failed to complete a timely investigation of abuse that had been reported on January 16, 2012; failed to ensure a policy for pacemakers; and failed to report the allegation of abuse made on January 16, 2012 to the State.  The Immediate Jeopardy was effective from January 16, 2012 through March 2, 2012. A written Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on March 6, 2012 and corrective actions were validated as having been completed on March 6, 2012. The verification of the allegation of compliance was conducted on-site on March 6, 2012. The verification of the allegation of compliance was confirmed by:  1.) Reviewing the facility's revised policy for Abuse Prevention/Reporting Investigation to include more comprehensive information related to identification, preventing occurrences, reporting, investigating, protecting, and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	1000 H	(EACH CORRECTIVE ACTION S	HOULD BE	COMPLETION
which removed the immediacy of the jeopardy, was received on March 6, 2012 and corrective actions were validated as having been completed on March 2, 2012 through review of the facility documents and staff interviews conducted on-site on March 6, 2012. The verification of the allegation of compliance was confirmed by:  1.) Reviewing the facility's revised policy for Abuse Prevention/Reporting Investigation to include more comprehensive information related to identification, preventing occurrences, reporting, investigating, protecting, and	F 226	interview confirmed until February 16, Time and Attendarevealed the LPN and 28, 2012 (for interview confirmed to the facility on Formated until Facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the allegange 16, 2012 to the State of the facility had not complete a timely been reported or ensure a policy freport the facility had not complete a timely been reported or ensure a policy freport the facility had not complete a timely been reported or ensure a policy freport the facility had not complete a timely been reported or ensure a policy freport the facility had not complete a timely been reported or ensure a policy freport the facility had not complete a timely been reported or ensure a policy freport the facility had not complete a timely had not complet	ed LPN #1 was not suspended 2012. Review of the facility ince Records for February 2012 worked on February 24, 27, a total of 3 days). Continued ed LPN #1 was allowed to return february 24 to work in the facility face duties; LPN #1 was not february 28, 2012; and the impleted it's investigation until ed 5, 2012, at 3:30 p.m., in the ffice with the Administrator cility failed to immediately used perpetrator; failed to y investigation of abuse that had a January 16, 2012; failed to or pacemakers; and failed to tion of abuse made on January State.  Jeopardy was effective from 2 through March 2, 2012. A ble Allegation of Compliance,	F	226			
reporting, investigating, protecting, and		which removed was received or actions were va on March 2, 20 documents and on March 6, 20 allegation of co  1.) Reviewing the Abuse Preventing include more controlled in the identification.	the immediacy of the jeopardy, in March 6, 2012 and corrective lidated as having been completed 12 through review of the facility staff interviews conducted on-site 12. The verification of the impliance was confirmed by:  The facility's revised policy for its interviews information related preventing occurrences,	Э				
Facility ID: TN4702 IT CONTINUATION SHEET 499		reporting, inves				Facility ID: TN4702	f continuation s	sheet Page 17 o

CENTE	RS FOR MEDICARI	& MEDICAID SERVICES	Lower	I II TIDI	E CONSTRUCTION	(X3) DATE	SURVEY LETED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING		COMP	3
AND PLAN	OF CORRECTION		B. WIN			03	C /06/2012
		445114	B. Will		CITY STATE ZIP CO		
NAME OF	PROVIDER OR SUPPLIER			STRE 583	ET ADDRESS, CITY, STATE, ZIP CO BY LYONS VIEW PIKE		
BRAKE	BILL NURSING HOM	E INC.		KN	IOXVILLE, TN 37919		(VE)
Divini		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CO		COMPLETION DATE
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TAG	REGULATORY	RESC IDENTIFY THE INTERIOR			DE IGE		
-			_	006			
F 22	26 Continued From	page 17	-	226			
	procedures.					8	
	2 ) Peviewing the	e facility's new policy and					
1	inservice records	s for Pacemaker Checks					
	procedure.	20					
1	2 \ Reviewing th	e facility's new policy and					
	inservice record	s for the new				•	
1	Pacemaker/Def	ibrillator procedure.					
	4 ) Conducted i	nterviews with CNA's and LPN's					
	1 11 -11 - 11 - 1	LEAD AGAIN SIZIL UII AII UIIIO, SI					
	-1-551-	ensure all had received inservices ention/Reporting investigation and	<b>'</b>				
	- lala ha idi	and whose of abuse and when					
							1
	inservice recor	ds on abuse, dated water inserviced prior to					
		- DOVIGNOUS OF THE PACIFIC PIGHT 19.				7/ 🐷	
1	1-ff in he inco	DICEN ON ADUSE DITOL TO LOTATION OF			8		-
1	to work if staff inservices.	had not attended the abuse					
			for				
1	5.) Reviewed	an additional six medical records	0.				
	residents with						
	6.) Reviewed	an additional six medical records	tor				
	residents on (	Comfort Only Care.					
	7 ) Reviewed	an additional three medical record	ds				İ
1							
		It suspected abuse repertures a suspected abuse repertures the facility was following and investigating.				2	
			Ì		*		
	Non-Complia	ance continues at a "D" level for					
		orrective actions. The facility is ubmit a plan of correction.					
	required to s	donne a pre-					1 1 Dans 40
					Facility ID: TN4702	If continuati	on sheet Page 18

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			T TO THE TOTAL OF	(X3) DATE SUF	RVEY
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	COMPLETED	
AND FLAN OF	CORRECTION		A. BUII	LDING	3	) c	: }
		445114	B. WIN	IG		03/06	/2012
NAME OF PE	ROVIDER OR SUPPLIER	In the second se		STR	EET ADDRESS, CITY, STATE, ZIP CODE		1
BRAKER	ILL NURSING HOME	INC.			837 LYONS VIEW PIKE NOXVILLE, TN 37919		
סוטונבט				l n	DROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE 1	COMPLETION DATE
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F 309	C/O #29340	CARE/SERVICES FOR	F	309			=
SS=J					:SSJ		
00.0						-11 6	3月12
1	Each resident mu	st receive and the facility must sary care and services to attain	W	/hat	corrective action will be accompli resident's found to be affected by	the	
	or maintain the his	ghest practicable physical,	d	efici	ent practice that facility failed to e	nsure statt	
	mental, and psycl	nosocial well-being, in	-	dhe	red to physician orders, caused or	was likely	
	accordance with the and plan of care.	the comprehensive assessment	to	ca	use serious harm injury, impairme	nt or death	
	and plan of care.				sident # (5)?		
			٨.	lo in	nmediate correction could not be	done as	
	This DECLUDEN	ENT is not met as evidenced			nt expired on 10/27/11 with Termin	al	
	by:	ENT IS NOT MET AS EVICEMENT	0	liagi	nosis.		
	Based on medic	al record review, facility policy	F	łow	will the facility identify other resid	lents	
	review, review of	literature on pacemaker of facility documents, and	P	avit	ng the potential to be affected by t lient practice; and what corrective	ne same	
	interview the fac	ility failed to ensure a staff			ient practice; and what corrective	donon wiii	
	member followed	physician orders for services				-41 The	
	rendered. A Lice	ensed Practical Nurse (LPN) on the chest of one resident	1	All r	esident's have potential to be affe ity has a process by which all phy	ctea. The sician	
	(#5), who had an	implanted cardiac pacemaker.		orde	are verified by the practicing no	urse prior to	
				201/	natient treatment/intervention. A 2	4-hour	
	The facility's failt	are to ensure staff adhered to caused or was likely to cause	1 .	chai	t check is done daily, by the 11-7	nurses on	1
	serious harm, in	iury, impairment, or death to one		all o	rders written in the previous 24-he ervice regarding verification of a pl	hvsician	
	resident (#5) of	sixteen residents reviewed.	3 8	orde	er for any patient procedure/treatn	ient was	
	The Administrati	or, Director of Nursing, and Unit		nroi	vide to all licensed staff in concert	with abuse	
	Manager were in	oformed of the immediate		train	ning by the DON, Unit Managers of 1 3/2/12. Nurse auditor/QI Nurse wi	n 2/29/12 Il audit 10%	
	Jeopardy in the	office of the Administrator on		thru	ctive charts weekly for complianc	e of	
	March 5, 2012,	at 2:15 p.m.		phy	sician orders with treatment plan.		-
	The findings inc	luded:					
	Resident #5 was January 17, 201	s admitted to the facility on 1 with diagnoses to include					

ME OF PROVIDER OR SUPPLIER RAKEBILL NURSING HOME	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445114	A. BUILDIN B. WING _ STE	PLE CONSTRUCTION  REET ADDRESS, CITY, STATE, ZIP CO. 1837 LYONS VIEW PIKE (NOXVILLE, TN 37919  PROVIDER'S PLAN OF CO. (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY.	OMB NO. 0  (X3) DATE SUR COMPLETI  03/06  DDE  DRRECTION IN SHOULD BE E APPROPRIATE	VEY
F 309 Continued From F Cardiac Dysrhyth Atrial Fibrillation, Hypertension, Hy Obstructive Pulm Chronic Pain.  Medical record r dated October 1 was rarely able sometimes able short and long to severely impain two person assistar and was incommoded in the severely impains two person	mia with Pacemaker Implant, Chronic Anticoagulant Therapy, reprlipidemia, Anemia, Chronic nonary Disease, Depression, and eview of the Minimum Data Set, 4, 2011, revealed the resident to understand others; was to make self understood; had term memory deficits; had ed decision making skills; required istance for bed mobility and non-ambulatory; required two noe for all activities of daily living; tinent of bowel and bladder. If review of the results from the naker monitoring company, dated and August 25, 2011, revealed r. Medtronic, Inc. VERSA VEDRO1 of device implanted)Implant date 010Diagnosis: SSS (Sick Sinus malfunction of the heart's primary ausing an abnormal heart rhythm) and review of the recapitulation reders, dated October 1 - 31, 2011, resident was initially ordered to be Not Resuscitate) on January 17, 20 ord review of the Medication ion Record, dated October 1 - 31, alled the resident was identified as	syst ensite and pace as place are a a a a a a a a a a a a a a a a a	t measures will be put into placemic changes that will be put ure the deficient practice does that will be put ure the deficient practice does the process of all residents who remaker will be maintained and rese. This list will be utilized to be remaker checks are scheduled to presence of order, frequents update, and presence of an update, and presence of an update, and presence of an ective. The pacemaker check viewed every Friday by the DC order to a daily basis. This process on a daily basis. This process of the corrective action will resident care plans.  How the corrective action will be resident to corrective action will be put into the deficient practice will be process. Any variance in practice will be process or any variance in practice of the CI committee will review determine continued frequent team consist of Medical Directors. Activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Directors, Social Workers House of the corrective activity Director, Dietary Director, Dietary Director, Dietary Director, Dietary Director, Dietary	have a d updated by a Q ensure d and monitored cy of check, care y advance log will be ON for complete rders for resident by the primary cedure is review 10% of current cord. will addres fort care orders fort care orders in ot recur. Whis o place? I Nurse weekly fo ctice will be the DON. All othe orted through the resis for six month y all findings to ncy of report. The ector, Administratic, MDS Coordinate in others in MDS Coordinate in others in Medical	ed s in at  y r 6 r QI s . QI tor, ors,

Maintenance Supervisor.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	riple construction	(X3) DATE SI COMPLE	
		445114	B. WING		03/0	6/2012
	ROVIDER OR SUPPLIER	INC.	S	TREET ADDRESS, CITY, STATE, 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY)	(X5) COMPLETION DATE
F 309	dated October 18, "have POA (Pow Directive (POST - Treatment) for CM  Medical record rev dated October 19, "Make pt (patien x-rays, no IV's (int no TF (tube feedir  Medical record rev updated October documentation of to be implemente related to the resi Not Resuscitate corder.  Medical record rev Nurse's Notes rev	2011, no time noted, revealed ver of Attorney) sign Advance Physician's Order for Scope of IO (Comfort Measures Only)"  view of the Physician's Order, 2011, no time noted, revealed at) CMO DNRno labs, no travenous fluids), no antibiotics, ng)"  view of the Plan of Care, 14, 2011, revealed no identification of or interventions d for the care of the resident dent's Cardiac Pacemaker, Doorder, or the Comfort Care only eview of the Clinical Record vealed the following sequential	F 30	9		
	notes: October 22 comfortable"; O "restingperiods of 3:00 p.m. to 11:0 quietlyperiods of 2011, at 2:30 a.m noted"; Octobe "Resident c/ (with Pronounced dear to 3:00 p.m. (shift spelling) Pacema Practical Nurse (2:00 p.m "(nai transport body to	2, 2011, at 2:30 a.m "resting october 23, 2011, at 4:00 a.m dis of apnea (not breathing for omfortable"; October 23, 2011, 0 p.m. (shift) - "resting of apnea noted"; October 24, n "restingperiods of apnea of 27, 2011, at 1:40 p.m n) no respirations or pulse. th"; October 27, 2011, 7:00 a.m. ft) - "Deactived (questionable aker" signed by Licensed (LPN) #1; October 27, 2011, at med) funeral home here to				

CENTERS FOR MEDIC TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION	11 12	TED C 6/2012
NAME OF PROVIDER OR SUP		STREE	ET ADDRESS, CITY, STATE, ZIP COD 7 LYONS VIEW PIKE		
BRAKEBILL NURSING		ID	ID PROVIDER'S PLAN OF CORPERING (EACH CORRECTIVE ACTION		(X5) COMPLETION
(A4) ID	RY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
the Assistan (Certified No office had seed of had seed office had seed of	ry 16, 2012, no time noted, signed by t Administrator, revealed "CNA arsing Assistant) #1 entered nursing everal complaints about LPN #1. why a magnet was placed on 's chest on the day (resident #5) CNA #1 did not work on the day of 's) death October 27, 2011(CNA ed all complaints with (named) or and (named) DON (Director of	5, y			
Interview I 2012, at 8 2011, aro resident # observed covered" Continue alive and interview the devic Continue never se interview observat told by C	by phone with CNA #2 on February 2:25 p.m., confirmed on October 27, and lunchtime, CNA #2 was cleaning 5 along with CNA #3 and #4 and "a doughnut shaped red plastic device on the chest of resident #5. If interview confirmed the resident was breathing at the time. Continued revealed CNA #2 asked LPN #1 what was and was told to "leave it alone in the device before. Continued revealed the CNA was talking about it interview confirmed the CNA had been the device before. Continued revealed the CNA was talking about it in sometime around Christmas and NA #1 that the device was a magnet to be used on a dying pacemaker pareported the incident to Administration.	the was and tient.			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 03/06/2012	
	ROVIDER OR SUPPLIER			58	EET ADDRESS, CITY, STATE, ZIP CODE 37 LYONS VIEW PIKE NOXVILLE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ıx	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	January 16, 2012.  Interview by phone 2012, at 10:10 a.m. helping clean resigned observed what white tape on the #5. Continued into was breathing at confirmed when L device the LPN to Leave it alone. CNA #3 stated so CNA #1 overhead incident and told used with a pace.  Interview by phone 2012, at 10:40 a.m. helping clean resigned up workest of resident revealed the resinterview confirm with the skin of the collarbone at the collarbone at the collarbone at the signed by the Administrator or review of an uncreceived by the signed by the Alfo, 2012, regard presence for the February 13, 200 and pres	e with CNA #3 on March 3, n., confirmed CNA #3 was dent #5 on October 27, 2011 at looked like "a roll of red and left side of the chest" of resident erview confirmed the resident the time. Continued interview PN #1 was asked about the old CNA #3 "It's a magnet. Continued interview confirmed ometime around Christmas 2011 of CNA #3 talking about the CNA #3 a magnet was not to be maker.  The with CNA #4 on March 3, m., confirmed CNA #4 was sident #5 on October 27, 2011, n., and observed what "looked thite tape on the left side of the time. Continued interview ident was breathing. Continued ned the device was in contact the resident and visible between	d	309			

	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		ONSTRUCTION	OMB NO.  (X3) DATE SU COMPLE	0938-0391 RVEY
ND PLAN OF CORRECTION		B. WING	G		03/0	6/2012
	445114			ADDRESS, CITY, STATE, ZIP COD	E	1
NAME OF PROVIDER OR SUPPLIER		1	E027 1	YONS VIEW PINE		
	INC	1	KNO	VALLE TN 37919	PECTION	(X5)
BRAKEBILL NURSING HOME		ID	1	PROVIDER'S PLAN OF COM	SHOULD BE	COMPLETION
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENC TAG REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	FIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	
#1 on February revealed LPN #1 magnet on reside pacemaker when Medical Director attending physic 11:30 a.m., reve knowledge of the magnet on the C27, 2011 until F completed a phe Director. Contil Physician's ord on resident #5 pacemaker more company performagnet to be resident with a linterview on Madministrator confirmed LF of resident #1 alive at the timesident's chemical policies for Canada and Measures Company 16.	esent while TBI Interviewed 2.7 vi. 3, 2012. Continued interview informed TBI about placing a ent #5's chest to deactivate the resident #5 was still living.  Activity Therapy room with the who was the resident's ian, on February 29, 2012, at ealed the Medical Director had not eallegation of LPN #1 placing a chest of resident #5 on October ebruary 13, 2012 when the TBI one interview with the Medical nued interview confirmed no er was written to utilize a magnet for any reason other than onitoring as directed by the orming the readings on the soly the company. Continued if the room or on the chest of an in the room or on the chest of an in the room or on the chest of an early service was no reason for a single the reading the chest of an in the room or on the chest of an early service was no reason for a single the room or on the chest of an early service was no reason for a single the reading the chest of an early service was no reason for a single the reading the reading the chest of an early service was no reason for a single the reading the rea	y e est se e	309	Facility ID: TN4702	If continua	tion sheet Page 24

PRINTED: 03/23/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME INC.    STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
BRAKEBILL NURSING HOME INC.    Country   Summary statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   Deficiency Must be Preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   PROPRIET ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EAC			445114				
PREFIX TAG  FOR CONTINUED FOR DESCRIPTION OF DEEP PROCESS OF PULL (EACH CORRECTIVE ACTION SHOULD BE PRECEDED OF FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 309  Continued From page 24 was received on March 6, 2012 and corrective actions were validated as having been completed on March 2, 2012 through review of the facility documents and staff interviews conducted on-site on March 6, 2012. The verification of the allegation of compliance was confirmed by:  1.) Reviewing the facility's revised policy for Abuse Prevention/Reporting Investigation to include more comprehensive information related to identification, preventing occurrences, reporting, investigating, protecting, and procedures.  2.) Reviewing the facility's new policy and inservice records for Pacemaker Checks procedure.  3.) Reviewing the facility's new policy and inservice records for he new Pacemaker/Deficiliator procedure.  4.) Conducted interviews with CNA's and LPN's on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1-2, 2012, to ensure all staff were inserviced prior to returning to work if staff had not attended the abuse inservices.  5.) Reviewed an additional six medical records for			EINC.	s	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		
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inservice records for Pacemaker Checks procedure.  3.) Reviewing the facility's new policy and inservice records for the new Pacemaker/Defibrillator procedure.  4.) Conducted interviews with CNA's and LPN's on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1-2, 2012, to ensure all staff were inserviced prior to returning to work. Review of the facility plan for staff to be inserviced on abuse prior to returning to work if staff had not attended the abuse inservices.  5.) Reviewed an additional six medical records for		Abuse Prevention include more conto identification, preporting, investigation.	n/Reporting Investigation to inprehensive information related preventing occurrences,				
inservice records for the new Pacemaker/Defibrillator procedure.  4.) Conducted interviews with CNA's and LPN's on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1-2, 2012, to ensure all staff were inserviced prior to returning to work. Review of the facility plan for staff to be inserviced on abuse prior to returning to work if staff had not attended the abuse inservices.  5.) Reviewed an additional six medical records for		inservice records	e facility's new policy and s for Pacemaker Checks				
on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1 -2, 2012, to ensure all staff were inserviced prior to returning to work. Review of the facility plan for staff to be inserviced on abuse prior to returning to work if staff had not attended the abuse inservices.  5.) Reviewed an additional six medical records for		inservice records	s for the new				
5.) Reviewed an additional six medical records for residents with pacemakers.		on all units, Hou Activity staff to e on Abuse Preve were able to ide and how to repoinservice record 2012, to ensure returning to wor staff to be insert to work if staff to	sekeeping staff on all units, and ensure all had received inservices intion/Reporting investigation and ntify types of abuse and when ort. Reviewing of the facility's is on abuse, dated March 1 -2, all staff were inserviced prior to the Review of the facility plan for yiced on abuse prior to returning				
		5.) Reviewed a residents with p	n additional six medical records fo pacemakers.	or			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1Y8P11

Facility ID: TN4702

PRINTED: 03/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 445114 03/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 309 Continued From page 25 F 309 6.) Reviewed an additional six medical records for residents on Comfort Only Care. 7.) Reviewed an additional three medical records of incidents of suspected abuse reported since March 2, 2012 to ensure the facility was following the procedures for reporting and investigating. Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a plan of correction. C/O #29340 F 490 483.75 EFFECTIVE F 490 3/15/12 ADMINISTRATION/RESIDENT WELL-BEING SS=J A facility must be administered in a manner that F490 SS=J enables it to use its resources effectively and efficiently to attain or maintain the highest What corrective action will be accomplished for practicable physical, mental, and psychosocial the resident found to have been affected by the well-being of each resident. deficient practice, that facility failed to administer in a timely manner to protect resident from abuse and ensure abuse does not recur? Facility's This REQUIREMENT is not met as evidenced failure was likely to have caused harm, injury. impairment or Death. Based on medical record review, facility policy review, review of literature of pacemaker devices, Unable to do immediate corrective action as review of facility documents, and interview, the resident had expired on 10/27/11. facility failed to be administered in a manner to

FORM CMS-2567(02-99) Previous Versions Obsolete

resident #5.

abuse.

protect residents from abuse, ensure abuse does not reoccur, and to ensure services rendered

The facility's failure caused or was likely to cause serious harm, injury, impairment or death to

were according to physician orders for one resident (#5) of sixteen residents reviewed for

Event ID: 1Y8P11

Facility ID: TN4702

If continuation sheet Page 26 of 29

No pg 27.28 -3/27/12 7:45 AM called Norma Lindsuy - She will fax immediately - Mad. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FAX NO. 8655842122

P. 02

PRINTED: 0	3/23/	2012
FORM A	PPRO	VED
OMB NO. 0	938-0	0391

CENTERS FOR MEDICARI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLET	ED
		445114	B. WING		03/06	; ;/2012
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIF 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919	CODE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 490	Continued From p	age 26	F 49	00	893	
	Manager were info Jeopardy in the of March 5, 2012, at The findings included in the Activity in the Activity Therator. Interview with the magnet on the checompleted a phore Director.  Interview with the the Activity Therator. Interview with the allegation of a magnet on the chimplanted cardiac was alive. Continuous not suspendent was not suspendent eview of the fact Records for February and the Activity of the fact Records for February 24 to we care duties and was 2012. Continuous at the Activity Therator.	19	hav prace All to be on a second was Con are 2/2: pace Con are Con are Con are Con are Con are Con an are Con are Con are Con an are Con are C	withe facility will identify other ing the potential to be affective ing the potential to be affective ing the potential to be affective include.  I presidents with pacemakers have affected by abuse. All staff revised abuse policy of report investigating. Abuse policy investigating. Abuse policy is maker checking by DON and its analysis. The Documentation of each of the policy is done by the Don/Unit Manarapetency will be verified as a scheduled. Abuse Inservice is scheduled. Abuse	ave the potential of were Inserviced ring, preventing was revised on ON and approved was developed on a Medical Director ducation policy gers on 3/13/12. pacemaker checks was done on a revised policy on a 3/13/12). Indate Physician on. place to ensure ecur?  If on checking and akers. Facility has and investigating ON and Unit incident ed for reporting to will immediately that abuse is	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/23/2012 FORM APPROVED OMB NO. 0938-0391

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				On Division		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLET	LED	
		44544	B. WI	NG.		02/05	5/2012	
		445114					12012	
NAME OF P	ROVIDER OR SUPPLIER	F.4		STREE	T ADDRESS, CITY, STATE, ZIP COE 7 LYONS VIEW PIKE	JE		
BRAKEB	ILL NURSING HOME	INC.			DXVILLE, TN 37919			
	STRAMA BY ST	ATEMENT OF DEFICIENCIES	1D	1	PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	DATE	
F 490	Continued From pa	age 27	F	490		3		
	March 1, 2012.		200		u tion will be mo	nitored to		
90			Но	w the	corrective action will be mon nat the deficient practice will	I not recur?		
		5, 2012, at 3:30 p.m., in the	en	виге и	ISE THE DELICICITE PRESSURE			
	Administrator's office with the Administrator confirmed the facility failed to immediately suspend the accused perpetrator; failed to complete a timely investigation of abuse that had been reported on January 16, 2012; failed to ensure a policy for pacemakers; and failed to report the allegation of abuse made on January 16, 2012 to the State.  Refer to F-223 Refer to F-226			Nurse will be checked for competency on checking pacemakers quarterly by DON or her designated Unit Coordinators. Staff will be Inserviced quarterly and PRN on reporting, prevention and investigation of abuse. DON or Unit Coordinators will report in QI Quarterly times four, number type of abuse allegations and what was done to resolve each case, to identify trends, patters and educational needs.  Pacemaker/Physician orders are monitored by the				
	Refer to F-309		מ	ON on	a weekly basis (every Frida)	y) and		
			re	portec	to the Ql Nurse weekly for	6 months. Any		
	The Immediate Je	opardy was effective from through March 2, 2012. A	V	ariance	es in practice will be immedi ated by the DON. All other p	atery shysician		
9	written Acceptable	Allegation of Compliance,	10	ıvestig rders v	vill be reported through the	QI Nurse's		
	which removed the	e immediacy of the jeopardy,	A	udit or	a weekly basis for six mon	iths. The QI		
54	was received on M	larch 6, 2012 and corrective		ommit	tee will review all findings to	o determine		
	actions were valid	ated as having been completed through review of the facility	C	ontinu	ed frequency of report. QI To cal Director, Administrator, I	eam consists Pharmacist		
	documents and st	aff interviews conducted on-site	0	t Mean	nit Coordinator, MDS Coord	inator, Rehab		
	on March 6, 2012.	The verification of the	L A	langer	Activity Director, Dietary M	lanager,		
	allegation of comp	liance was confirmed by:	1	lousek	eeping , Maintenance Super	visors and		
	1 \ Reviewing the	facility's revised policy for		fedical	Records.			
	Abuse Prevention	Reporting Investigation to	,	his old	an of correction is submitted	d as required		
	include more com	prehensive information related		inder S	State and Federal Law and di	oes not		
**	to identification, pr	reventing occurrences,		onstiti	ute an admission on the par-	t of the Facility		
	reporting, investigating, protecting, and procedures.			that the findings cited are accurate, or that the				
	**************************************		findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies					
	2.) Reviewing the	facility's new policy and	were cited correctly applied.					
	inservice records for Pacemaker Checks procedure.			1				
	procedure.	9		i				

Event ID: 1Y8P11

Facility ID: TN4702

TATEMENT	ENT ERS FOR MEDICARE & MEDICAID SERVICES  TEMENT OF DEFICIENCIES O PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C 03/06/2012
	ROVIDER OR SUPPLIER		5	REET ADDRESS, CITY, STATE, ZIP CODE 1837 LYONS VIEW PIKE KNOXVILLE, TN 37919	
(X4) ID PREFIX TAC:	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE DATE
F 490	3.) Reviewing the inservice records of Pacemaker/Defibrous and units, House Activity staff to end on Abuse Prevent were able to identify and how to report inservice records 2012, to ensure a returning to work staff to be inservice to work if staff had inservices.  5.) Reviewed an a residents with pace 6.) Reviewed and residents on Correct To.) Reviewed and of incidents of summer to graph of the procedures for Non-Compliance monitoring correct monitoring correct the procedures for the procedure of the procedu	facility's new policy and for the new illator procedure.  erviews with CNA's and LPN's excepting staff on all units, and sure all had received inservices ion/Reporting investigation and ify types of abuse and when Reviewing of the facility's on abuse, dated March 1 -2, Il staff were inserviced prior to Review of the facility plan for ced on abuse prior to returning d not attended the abuse additional six medical records for cemakers.		Colded to Place Cornection with of adm. Normal street over see to ensure cornective action completed. The Directon will consult with a consult with a consult completed. The Directon will completed. The Directon will completed. The Directon will completed. The Directon will completed. The noise for will awality clasure involvement a monitoring of	Ann Dyke RW  ator will  we all  medical  eny Standard  will over see  en Medical
				lf o	ontinuation sheet Page 29 of 29